Section 5: Submitting Claims to Medicaid

Time Limits for Filing Claims

All Medicaid claims, except inpatient claims and nursing facility claims, must be received by EDS within 365 days of the **first date** of service in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the **last date** of service on the claim.

Claims for behavioral health services provided to recipients of the Piedmont Cardinal Health Plan (PCHP) catchment area must be filed with the PCHP within 90 days of the date of the service was provided.

Submitting Claims Electronically

Providers who plan to submit claims electronically must indicate their intention to do so by agreeing to abide by the conditions for electronic submission outlined in the Electronic Claims Submission Agreement.

The process of submitting claims to Medicaid through electronic media is referred to as electronic commerce services. EDS will process claims submitted through file transfer protocol and asynchronous dial-up.

Billing electronically requires software that complies with the transaction standards mandated by HIPAA. Refer to **Section 10, Electronic Commerce Services,** for additional information about electronic billing and ECS services.

The rest of this section will focus on paper claim submission.

Submitting Claims on Paper

When completing the paper claim form, use black ink only. Do not submit carbon copies or photocopies, and do not highlight the claim or any portion of the claim. For auditing purposes, all claim information must be visible in an archive copy. EDS uses optical scanning technology to store an electronic image of the claim, and the scanners cannot detect carbon copies, photocopies, or any color of ink other than black. Carbon copies, photocopies, and claims containing a color of ink other than black, including highlighting, will not be processed and will be returned to the provider.

The CMS-1500 (12/90), the UB-92 and the American Dental Association (ADA) 2002 paper forms have been revised and replaced with the CMS-1500 (08/05), the UB-04 and the ADA 2006 claim forms, respectively. **N.C. Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA.** For information related to claim filing requirements and billing guidelines, refer to N.C. Medicaid program information and policies, found at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Processing Paper Claims without a Signature

Providers are allowed to file **paper** claims without an original signature on each claim if the provider submits a **Provider Certification for Signature on File** form. (Providers who file claims electronically are not required to complete this form. Refer to **Submitting Claims Electronically** below.) Please note that out-of-state providers (providers beyond the 40-mile border of North Carolina border) are required to have a signature on each claim.

Forms that must be signed must contain the provider's original signature; stamped signatures are not accepted. For group physician/practitioner practices or clinics, each attending provider must sign a certification. Groups whose claims do not require an attending provider number—such as home health agencies, hospitals, and facilities (including adult care)—should have the certification signed by an individual who has authority to sign contracts on behalf of the provider. To avoid EOB 1350 denials (which indicate that a **Provider Certification for Signature on File form** has not been submitted), please contact EDS Provider Services at 1-800-688-6696 or 919-851-8888 prior to submitting claims to verify that the system has been updated.

A copy of the form is available on the DMA website at http://www.ncdhhs.gov/dma/formsprov.html. Fax or mail completed certifications two weeks in advance of submitting claims without a signature.

National Drug Code

According to the Deficit Reduction Act of 2005 (DRA), all physician-administered drugs must be billed with appropriate HCPCS code, National Drug Code (NDC), and NDC units.

Each drug or biologic product approved by the Food and Drug Administration (FDA) is given a unique NDC number. The NDC is found on the package and/or vial of medication. N.C. Medicaid allows for 10 NDCs to be billed per detail.

- Providers billing on a professional claim: When a HCPCS drug code, covered under the Physicians Drug Program (PDP), is billed at the detail level, the corresponding 11-digit NDC number must also be indicated for the corresponding detail. Refer to the fee schedule for the Physician's Drug Program for a list of covered PDP drugs (http://www.ncdhhs.gov/dma/fee/fee.htm).
- Providers billing on an institutional claim: When billing outpatient hospital or dialysis services under Revenue Codes 25X, 634, 635, and/or 636, include the corresponding HCPCS code, NDC, and NDC units for the detail. Refer to the August 2008 general Medicaid Bulletin (http://www.ncdhhs.gov/dma/bulletin.htm) for additional Revenue Code information.
- 340-B providers are not excluded from these requirements.

For more information on NDC requirements, refer to the October 2007 Special Bulletin, *National Drug Code Implementation*, on DMA's website at http://www.ncdhhs.gov/dma/bulletinspecial.htm.

Billing Professional (CMS-1500/837P) Claims

The following provider types submit Professional claims:

Ambulatory surgery centers At-risk case management services

Certified registered nurse anesthetists Children's Development Services Agencies

Chiropractors Community Alternatives Program services

Durable medical equipment suppliers Direct-enrolled independent behavioral health

Free standing birthing centers providers

Federally qualified health centers Health departments

Hearing aid dealers HIV case management services

Home infusion therapy services

Independent diagnostic testing facilities

Independent laboratories Independent practitioners
Local education agencies Local management entities

Maternity Care Coordination/Child Services Nurse midwives
Coordination services Nurse practitioners

Optical supply dealers Optometrists

Outpatient behavioral health services provided Orthotics and prosthetics suppliers

by Community Intervention Services Personal care services

Agencies Physicians

Podiatrists Planned Parenthood (non-medical doctor)

Portable X-ray services organizations
Private duty nursing services Rural health clinics

Modifiers

Some provider types are mandated to bill Medicaid using modifiers. A modifier allows a provider to indicate that a service rendered to a patient has been altered by some special circumstance(s) while the code description remains the same. If no special circumstances exist and further description of the service rendered is not needed, the code should be billed without a modifier.

For additional billing information, refer to the service-specific clinical coverage policies on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Instructions for Billing Professional Claims

These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the National Uniform Claim Committee (NUCC). The NUCC instruction manual can be found at www.nucc.org. N.C. Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines, refer to N.C. Medicaid program information and policies found at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Definitions

MPN: Medicaid Provider Number, DMA-issued 7-digit number received upon enrollment.

NPI: National Provider Identifier, NPPES-issued 11-digit number received upon request.

Taxonomy Code: 10-character code that represents provider type and specialty.

Qualifier: Identifies whether the number to the immediate right on the claim represents a value.

Qualifier	Value
1D	Medicaid Provider Number (MPN)
ZZ	Taxonomy Code

Please refer to the two claim examples on the following pages. DMA encourages all providers (except pharmacies and atypical providers) to submit their NPI, Medicaid provider number (MPN), and taxonomy on all claims until they receive an NPI Provider Ready letter confirming that their claims are mapping correctly to the MPN submitted on the claim.

Note: Refer to Section 11, National Provider Identifier for additional NPI information.

The first Professional claim example includes the MPN, NPI, and taxonomy code. Each block is noted to show the placement of this information.

The second Professional claim example does not include the MPN, but includes NPI and taxonomy code only. Each block is noted to show the placement of this information without the MPN.

CMS-1500 with MPN

1500

NPI Transition – CMS-1500

HEALTH INSURANCE APPROVED BY NATIONAL UNIFORM CLA								
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MEDICARE MEDICAID	TRICARE CHAMP	/A GROUP FECA OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)					
(Medicare #) (Medicaid #) (CHAMPUS (Sponsor's SSN) (Member)	D#) (SSN or ID) (SSN) (ID)	123456789K					
2. PATIENT'S NAME (Last Name, First Na	ame, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
Patient, Joe		01 15 62 MX F						
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)					
		Self Spouse Child Other						
123 Fun Street	STATE	<u> </u>	CITY STATE					
	NC	Single Married Other	OIT					
Fun Town ZIP CODE TELEPI	HONE (Include Area Code)	Single Marned Other	ZIP CODE TELEPHONE (Include Area Code)					
,	`	_ , _ Full-Time Part-Time	/ \					
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OTHER MINISTERS DATE OF BIRTH		YES NO	M F					
b. OTHER INSURED'S DATE OF BIRTH	SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME					
	M F	YES NO						
c. EMPLOYER'S NAME OR SCHOOL NAM	ME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME					
		YES NO						
d. INSURANCE PLAN NAME OR PROGRA	AM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?					
			YES NO # yes, return to and complete item 9 a-d.					
READ BACK OF 12. PATIENT'S OR AUTHORIZED PERSO	F FORM BEFORE COMPLETIN	G & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize					
to process this claim. I also request payr	ment of government 17a. 1D	qualifier and CA	payment of medical benefits to the undersigned physician or supplier for services described below.					
below.		zation or referral						
SIGNED			SIGNED					
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billing taxonomy	SOURCE 17	1D 8900000	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY					
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	referring p	roviders.	AUTHORIZATION NUMBER					
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		33a. Billin	Billing MPN					

CMS-1500 without MPN

[1500]

HEALTH INSUBANCE CLAIM FORM

NPI Implementation – CMS-1500 with NO MPN

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(Medicare #) (Medicaid #) (Sponsor's SSN) (Membe	— HEALTH PLAN — BLK LUNG —	123456789K	
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
Patient, Joe 5. PATIENT'S ADDRESS (No., Street)	01 15 62 MX F	7. INSURED'S ADDRESS (No., Street)	
123 Fun Street	Self Spouse Child Other		
CITY STAT	E 8. PATIENT STATUS	CITY	STATE
Fun Town NC	Single Married Other		
ZIP CODE TELEPHONE (Include Area Code)	Employed Student Student	ZIP CODE TELEPHONE (Include Area (Code)
11111 (555) 555-5555 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX	FП
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT?	b. EMPLOYER'S NAME OR SCHOOL NAME	<u>- Г</u>
MM DD YY M F	YES NO	B. EM ESTETIONAME STIGSTIGSETOME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
J. INSURANCE PLAN NAME OR PROGRAM NAME	YES NO	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
S. INCOMPAGE FLAN NAME ON PROGRAM NAME	10d. RESERVED FOR LOCAL USE	YES NO # yes, return to and complete it	tem 9 a-d.
READ BACK OF FORM REFORE COMPLETE 12. PATIENT'S OR AUTHORIZED		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I a	uthorize
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override or an aty SIGNED Otherwise leave b	pical provider number.	SIGNED	
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<u> </u>	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERV	/ICES YY
19. RESERVED FOR LOCAL USE	17b. NPI 1234567890	PROM TO 1	
17b. NPI for	CA authorization or referral	YES NO	
04 DIAGNOSIS OD NATI IDE OF ILLNESS (for CA overrides or atypica	DIGAID DECLIDATION ON	
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Quick Reference Guides for Carolina ACCESS Providers

Outlined below are specific requirements for recording Carolina ACCESS primary care provider (PCP) numbers, Carolina ACCESS overrides, and referring provider information on Professional claims. Please make note of these filing requirements.

Professional Claims Processed with CA PCP Authorization

Block	Block Name	Required Field Yes / No	Value	Explanation
17	Name of Referring Provider	No		
17a (smaller shaded box)	Qualifier	Recommended	1D	Qualifier 1D represents Medicaid provider number.
17a (larger shaded box)	PCP Referral Number	Recommended	CA PCP Medicaid provider number	Recommended to enter the CA PCP referral number (Medicaid provider number).
17b	NPI (National Provider Identifier)	Yes	CA PCP NPI number	Enter the CA PCP NPI linked to the PCP referral number.

Professional Claims Processed with CA Override

Block	Block Name	Required Field Yes / No	Value	Explanation
17	Name of Referring Provider	No		
17a (smaller shaded box)	Qualifier	Yes	1D	Qualifier 1D represents Medicaid provider number. If any other value is entered, the claim will be denied.
17a (larger shaded box)	CA Override Number	Yes	EDS-issued CA override number.	
17b	NPI	No		Will not have NPI of referring provider.

Billing Institutional (UB-04/837I) Claims

The following provider types submit Institutional claims:

Adult care homes

Ambulance services

Dialysis facilities

Home health agencies

Hospice services

Hospitals

Inpatient behavioral health services provided by Community Intervention Services Agencies Intermediate care facilities for individuals with mental retardation

Nursing facilities

Psychiatric residential treatment facilities

Residential child care (Level II, III, and IV) facilities

Instructions for Billing Institutional Claims

These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the National Uniform Billing Committee (NUBC). The NUBC instruction manual can be found at http://www.nubc.org. N.C. Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines, refer to N.C. Medicaid program information and policies, found at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Definitions

MPN: Medicaid Provider Number, DMA-issued 7-digit number received upon enrollment.

NPI: National Provider Identifier, NPPES-issued 11-digit number received upon request.

Taxonomy Code: 10-character code that represents provider type and specialty.

Qualifier: Identifies whether the number to the immediate right on the claim represents a value.

Qualifier	Value
G2	Medicaid Provider Number (MPN)
DN (Form Locator 78 only)	National Provider Identifier (NPI)
В3	Taxonomy Code

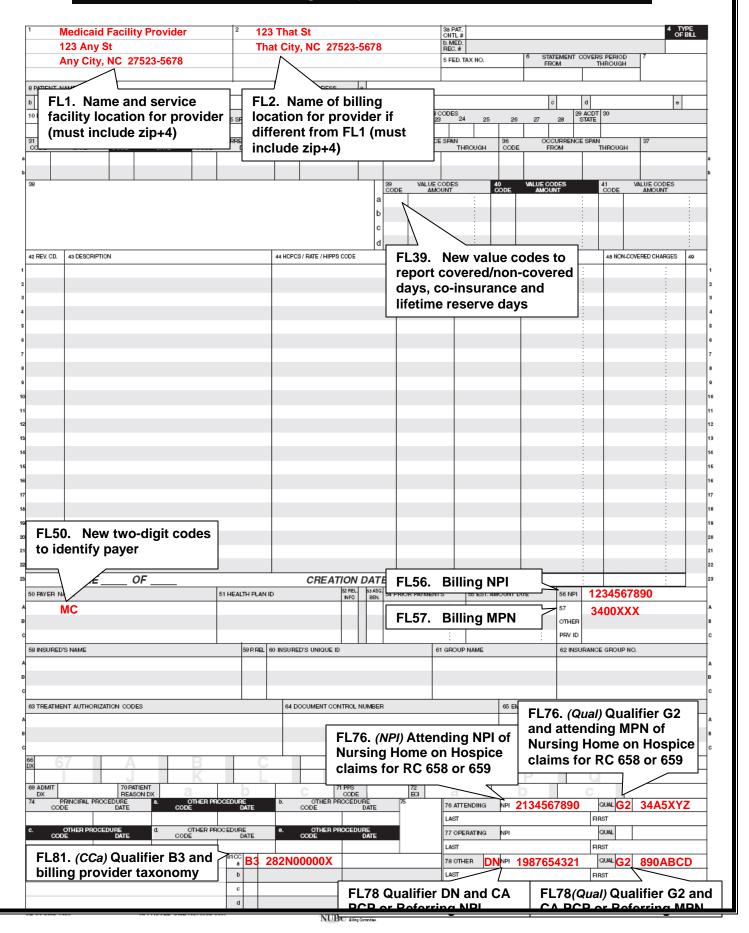
Please refer to the two claim examples on the following pages. DMA encourages all providers (except pharmacies and atypical providers) to submit their NPI, MPN, and taxonomy on all claims until they receive an NPI Provider Ready letter confirming that their claims are mapping correctly to the MPN submitted on the claim.

Note: Refer to Section 11, National Provider Identifier for additional NPI information.

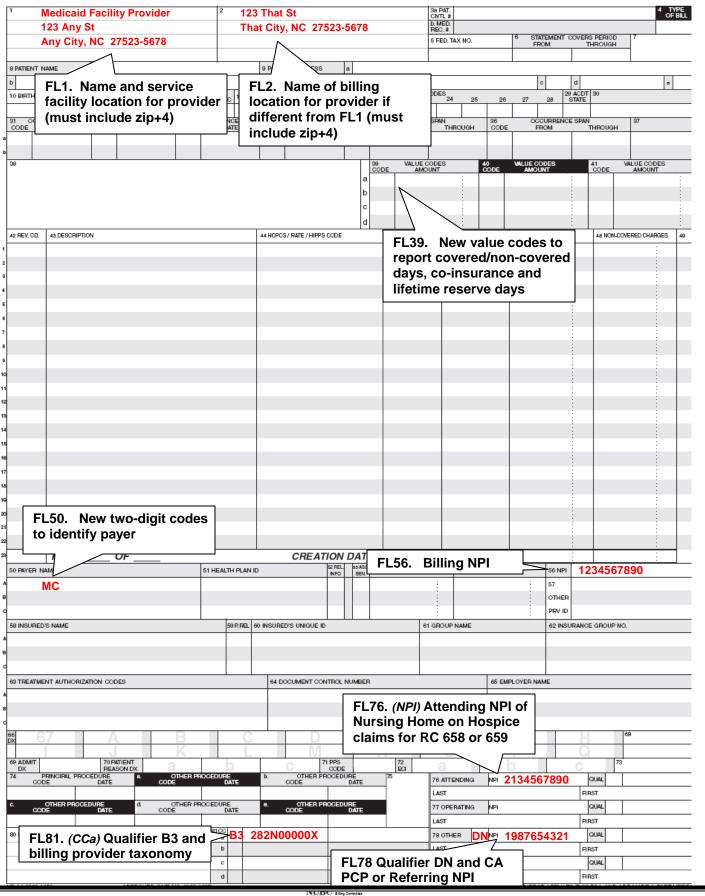
The first Institutional claim example includes the MPN, NPI, and taxonomy code. Each Form Locator is noted to show the placement of this information.

The second Institutional claim example does not include the MPN, but includes NPI and taxonomy code only. Each Form Locator is noted to show the placement of this information without the MPN.

UB with MPN



UB without MPN



Quick Reference Guides for Carolina ACCESS Providers

Outlined below are specific requirements for recording Carolina ACCESS PCP numbers, Carolina ACCESS overrides and referring provider information on Institutional claims. Please make note of these filing requirements.

Institutional Claims Processed with CA PCP Authorization

Form Locator	Description	Required Field Yes / No	Value	Explanation
78 (blank field 1)	Provider Type Qualifier Code	Yes	DN	DN indicates referring provider.
78 (blank field 2)	NPI	Yes	CA PCP NPI number	
78 (blank field 3)	Qualifier	Recommended	G2	Qualifier G2 represents Medicaid provider number. If any other value is entered, the claim will be denied.
78 (blank field 4)	PCP Referral Number or CA Override Number	Recommended	CA PCP Medicaid provider number	Enter the current CA PCP number (Medicaid provider number)
78 (blank field 5) Last	Last Name of Referring Provider	No		
78 (blank field 6) First	First Name of Referring Provider	No		

Institutional CA Claims Processed with CA Override Number

Form Locator	Description	Required Field Yes / No	Value	Explanation
78(blank field 1)	Provider Type Qualifier Code	No		
78 (blank field 2)	NPI	No		
78 (blank field 3)	Qualifier	Yes	G2	Qualifier G2 represents Medicaid provider number. If any other value is entered, the claim will be denied.
78 (blank field 4)	CA Override Number			
78 (blank field 5) Last	Last Name of Referring Provider	No		
78 (blank field 6) First	First Name of Referring Provider	No		

Billing Dental (ADA 2006/837D) Claims

The following provider types submit Dental claims:

- Dentist
- Federally qualified health center (dental services only)
- Health department dental clinic (dental services only)
- Rural health clinic (dental services only)

Refer to Clinical Coverage Policy #4, *Dental Services*, on DMA's website at http://www.ncdhhs.gov/dma/dental.htm, for instructions on completing the ADA claim form.

Definitions

MPN: Medicaid Provider Number, DMA-issued 7-digit number received upon enrollment.

NPI: National Provider Identifier, NPPES-issued 11-digit number received upon request.

Taxonomy Code: 10-character code that represents provider type and specialty.

Please refer to the two claim examples on the following pages. DMA encourages all providers (except pharmacies and atypical providers) to submit their NPI, MPN, and taxonomy on all claims until they receive an NPI Provider Ready letter confirming that their claims are mapping correctly to the MPN submitted on the claim.

Note: Refer to Section 11, National Provider Identifier for additional NPI information.

The first Dental claim example includes the MPN, NPI, and taxonomy code. Each block is noted to show the placement of this information.

The second Dental claim example does not include the MPN, but includes NPI and taxonomy code only. Each block is noted to show the placement of this information without the MPN.

Dental ADA with MPN

Dr. I.M. Smiley P.O. Box 1234 Any City, NC 27123-4567 56. Service Facility address with zip+4 49. NPI 50. License Number 51. SSN or TIN 52A. Additional Provider ID 52A. Additional Provider ID 53B. Additional Provider ID 549. Billing NPI 54. Attending NPI if A applicable Signed (TIP) 48. APPL 49. Address, City, State, Zip Code Any City, NC 27123-7890 58. Attending MPN if applicable TaxOntority if applicable. If no attending taxonomy, enter billing taxonomy 56. Service Facility address, City, State, Zip Code Any City, NC 27123-7890 58. Attending MPN if applicable TaxOntority if applicable. If no attending taxonomy	35. Remarks	
charges for dental services and materials not goat by my dental benefit plan, unless prohibited by law, or the treating dental or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. The settent permitted by law, lecrosent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. X Patient/Guardian signature Date 37. Ihereby authorize and direct paymentol, the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. X Subscriber signature Date 14. Date Applianos Placed (MM/DD/CCYY) 45. Treatment Resulting from Occupational illness /injury Auto accident (MM/DD/CCYY) 47. Auto Accident (MM/DD/CCYY) 48. Billing address with zip+4 code 18. Name, Address, City, State, Zip Code Dr. I.M. Smiley P.O. Box 1234 Any City, NC 27123-4567 56. Service Facility address with zip+4 51. SSN or TIN S2A. Additional S99ABCD 57. Phone Number - S8. Additional Provider D 899ABCD 18. Additional Provider D 899ABCD	AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION
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J400 (Same as ADA Dental Claim Form - J401, J402, J403, J404)

or go online at www.adacatalog.org

Dental ADA without MPN

35. Remarks					
AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION				
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.	38. Place of Treatment Provider's Office Hospital ECF Other 40. Is Treatment for Orthodontics? No (Skip 41-42) Yes (Complete 41-42) 39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s) 41. Date Appliance Placed (MM/DD/CCYY)				
Patient/Guardian signature Date	42. Months of Treatment Remaining 43. Replacement of Prosthesis? 44. Date Prior Placement (MM/DD/CCYY)				
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. X	45. Treatment Resulting from Occupational illness/injury Auto accident Other accident				
BILLING D zip+4 code	48. Date of Accident (MM/DD/CCYY) 47. Auto Accident State TREATING DENTIST AND TREATMENT LOCATION INFORMATION				
48. Name, Address, City, State, Zip Code Dr. I.M. Smiley P.O. Box 1234 Any City, NC 27123-4567	53. I hereby certify that the procedures as indicated by date at visits) or have been completed. 56a. Attending Taxonomy if applicable. If no attending taxonomy, enter billing taxonomy.				
56. Service Facility address with zip+4	54. NPI 2987654321 55. License wurn 56. Address, City, State, Zip Code 56A. Provider Specialty Code 123D00000X				
49. NPI 50. License Number 51. SSN or TIN 1234567890	Main Street Any City, NC 27123-7890				
52. PH N 49. Billing NPI 52A. Additional Provider ID	57. Phone () – 58. Additional Provider ID				

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Billing Pharmacy Claims

DMA mandates that all providers use the online, real-time Point of Sale (POS) system to process pharmacy claims. Paper and modem claims are allowed only in certain instances.

The online POS system automatically performs eligibility verification, drug validation, pricing, and edits and audits followed by Pro-DUR before the pharmacy dispenses a prescription. Immediate assurance of the amount to be paid for the prescription reimbursement submitted through online claims is sent on the next Medicaid checkwrite.

POS reduces follow-up accounting for Medicaid claims by allowing for the correction of any errors before the recipient gets the prescription. Pharmacists receive all of the reject codes immediately when a claim is submitted through POS; other submission methods are limited to returning the first reject encountered.

Where appropriate, a claim may be filed manually. The manual pharmacy claim form allows for billing 10 separate prescriptions within the same month of service. It may be used to bill for prescriptions dispensed to one recipient or for prescriptions dispensed to 10 different recipients.

Additional information on submitting Pharmacy claims can be found on DMA's website at http://www.ncdhhs.gov/dma/pharmacy.htm. Pharmacy newsletters are published monthly on DMA's website at http://www.ncdhhs.gov/dma/pharmnews.htm.

Medicare Crossover Claims

Claims filed to Medicare will be crossed over automatically to Medicaid. In order for the crossover claim to process, the NPI on the Medicare claim must be on file for a North Carolina MPN. It is the provider's responsibility to check the Medicaid Remittance and Status Report to verify that the claim was crossed over from Medicare.

Providers may verify that their NPI number is on file with Medicaid via the NPI and Address Database on DMA's website at http://www.ncdhhs.gov/dma/WebNPI/default.htm or by contacting EDS Provider Services at 1-800-688-6696 or 919-851-8888.

Note: Only one NPI can be reported for each MPN. If you have more than one NPI with Medicare but one MPN with Medicaid, you must choose the appropriate NPI to report to Medicaid.

Claims that do not crossover and have been paid by Medicare can be filed as an 837 professional transaction completing the Coordination of Benefits (COB) loop. Refer to the implementation guide at http://wpc-edi.com and the N.C. Medicaid HIPAA Companion Guide on DMA's website at http://www.ncdhhs.gov/dma/hipaa/compguides.html for instructions on completing the 837 professional transaction.

Claims that do not cross over and have been paid by Medicare can also be filed on a CMS-1500 claim form. The paper claim form must be submitted with the Medicare voucher attached.

Copayments

Services covered by **both** Medicare and Medicaid are not subject to a Medicaid copayment. However, if Medicare denies the service and the provider submits the claim to Medicaid, the recipient may be responsible for the appropriate Medicaid copayment.

Carolina ACCESS Primary Care Providers

Services covered by **both** Medicare and Medicaid are not subject to Carolina ACCESS PCP referral authorization. However, if Medicare denies the service and the provider submits the claim to Medicaid, the provider may be responsible for the Carolina ACCESS PCP referral.

Prior Approval

Medicaid does not require prior approval for Part B services that are covered by Medicare. However, if Medicare does not cover a service and Medicaid requires prior approval, the provider must obtain prior approval.

Annual Visit Limitation

Services covered by **both** Medicare and Medicaid are not subject to the annual visit limit per state fiscal year (July 1 through June 30). However, if Medicare denies the service and the provider submits the claim to Medicaid, the recipient may be subject to the annual visit limitation.

Hysterectomy, Sterilization, and Abortion Consents/Statement

Procedures covered by **both** Medicare and Medicaid do not require sterilization consent forms, hysterectomy statements or abortion statements in order to receive reimbursement for the procedures.

However, if Medicare does not cover the procedure, Medicaid requires the appropriate consent form/statements to be submitted. Forms must be mailed to the address listed on the form.

Durable Medical Equipment Span Dates

If a durable medical equipment claim is billed to Medicare with a span of dates, and the "to" date of service is in the future, providers must refile the claim to Medicaid after the "to" date of service on the claim has passed. Medicaid does not reimburse for future dates of service as Medicare does.

Optical Refractions

Because Medicare does not cover refractions, the service will be denied unless it is billed for a medical diagnosis. Providers must follow Medicare guidelines when billing for a refraction. If the patient also has Medicaid, the provider should bill Medicaid for refraction (CPT code 92015) with a refractive diagnosis. A copayment will be deducted for services not covered by Medicare unless the recipient qualifies for specific copayment exemptions.

Reimbursement Guidelines

<u>Part B – Professional Claims (CMS-1500/837p)</u>—Professional charges are reimbursed a specific percentage of the coinsurance and deductible in accordance with the Part B reimbursement schedule. The payment percentages are determined by the provider type and specialty. The payment percentages are available on DMA's website at http://www.ncdhhs.gov/dma/fee/fee.htm under "Medicaid Crossover Percentage Payment Schedule." **Providers cannot bill the recipient for any remaining balance. Medicaid's payment or non-payment is considered payment in full.**

<u>Part B – Institutional Claims (UB-04/837i)</u>–Institutional claims do not automatically cross over to Medicaid for payment. Once Medicare has adjudicated the claim, providers must file the claim with Medicaid as a secondary claim. Instructions for filing the claim as a secondary claim are as follows:

- FL4 Indicate the proper bill type
- FL31 through 36a-b, code A3-C3 Indicate that the Medicare Part A benefits are exhausted. Lifetime Reserve days must also be exhausted.
- FL50 Indicate Medicare as a payer.
- FL54 Indicate the Medicare Part B payment. Do not include the contractual adjustment for the Medicare Part B payment.
- FL80 Indicate that the patient has no Medicare Part A benefits.

Do not attach a copy of the Medicare EMOB with the claim form. If the Medicare EMOB is attached to the claim form, the claim will process incorrectly for payment.

Medicaid will process the claim by first calculating the Medicaid allowable as if Medicaid were primary. The Medicare payment is subtracted from the Medicaid allowable. The balance from the subtraction is compared to the patient liability and the lesser of the two amounts is paid.

If the Medicaid-allowed amount is more than the third-party payment, Medicaid will pay the difference up to the Medicaid-allowed amount. The payment (or nonpayment) must be accepted as payment in full.

Condition code D7 may be used to override Medicare Part A and condition code D9 may be used to override Medicare Part B when services are non-covered or services do not meet Medicare criteria.

Professional or Dental Claim Denials for Non-covered Services

If a Professional or Dental claim is denied by Medicare as non-covered, providers may file the claim to Medicaid.

- If the claim is submitted to Medicaid on paper, providers must submit a Medicaid Resolution Inquiry Form and attach a Medicare voucher indicating the Medicare EOB denial.
- If the claim is submitted electronically through the 837 professional transaction (dental providers must file using the 837 dental transaction) refer to the instructions outlined for the PWK segment for the 2300 loop in the N.C. Medicaid HIPAA Companion Guide on DMA's website at http://www.ncdhhs.gov/dma/hipaa/compguides.html.
- If the claim is submitted through the NCECSWeb tool, providers must indicate that paper work related to the Medicare denial as a non-covered service is on file at the provider's site. This is done by selecting the "Yes" button for "Paperwork on file at Provider Site for Medicare Override?" in the Miscellaneous Claims portion of the web tool.

Providers must not override Medicare when Medicare denies the service for lack of medical necessity.

Medicare Health Maintenance Organization

Professional Services

In order for Medicaid to consider payment for Medicare Health Maintenance Organization (HMO), providers are requested to bill only the **cost share** amount shown on the **Medicare EOB. Medicaid liability is only for the Medicare HMO cost share.** When filing on the CMS-1500 claim form, the following blocks must be completed:

- Blocks 24F, 28, and 30 should reflect the Medicare HMO cost share amount only. If blocks 24F, 28, and 30 do not reflect the Medicare HMO cost share amount, the claim will be returned to the provider for correction.
- Block 29 should reflect third party insurance payments only. Providers are not to indicate the Medicare HMO payment in this block. If the recipient does not have a third party insurance payment, the block should be left blank. If the Medicare HMO payment is indicated in block 29, the claim will be returned back to the provider for correction.

HMO example of CMS-1500 claim form without third party insurance, HMO EOB attached:

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All CMS-1500 claims for Medicare HMO should be submitted with the Medicaid Resolution Inquiry Form indicating that the claim attached is a Medicare HMO. The Medicaid Resolution Inquiry Form, as well as the CMS-1500 claim form, **and Medicare HMO EOB** should be mailed to:

EDS PO Box 300009 Raleigh, NC 27622

Institutional Services

In order for Medicaid to consider payment for Medicare HMO, providers are requested to bill all institutional charges on the UB-04 claim form. The claims should not be altered for processing purposes. The claim should be billed to Medicaid as it was billed to Medicare HMO.

Medicaid liability is only for the Medicare HMO cost share. The following information is required for claim processing:

- The claims must be submitted with a Medicare EOB attached to the claim. If the EOB is on multiple pages, please submit all of the pages of the EOB with the claim.
- All charges should be reflected on the UB-04 claim form. Do not combine or destroy the integrity of the claim by "rolling up" the charges into one revenue code.
- If the recipient has patient monthly liability or deductible, the information should be reflected on inpatient stays, if applicable.
- The cost share amount should be indicated in form locator 55 (Estimated Amount Due).
- Indicate in form locator 84 that "This is a Medicare HMO claim."

HMO example of UB-04 claim form, HMO EOB attached 43 DESCRIPTION 44 HCPC3 / RATE / HIPPS CODE 45 SERV. DATE 46 SERV, UNITS 47 TOTAL CHARGES 42 REV. CB. 48 NON-COVERED CHARGES 100108 110 500.00 500.00 PAGE OF CREATION DATE TOTALS 1234567890 340XXX 50 PKYER NAME 51 HEALTH PLAN ID 54 PRIOR PRIMENTS 55 EST. AMOUNT DUE **Medicare HMO Indicato** 100.00 OTHER 1234567890A 50.00 3400XXX PRV ID 58 INSURED'S NAME SORREL 60 INSURED'S UNIQUE ID 61 GROUP NAME 62 INSURANCE GROUP NO.

The UB-04 claim form with the Medicare HMO EOB attached should be mailed to:

DMA/Third Party Recovery 2508 Mail Service Center Raleigh, NC 27699-2508